STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155455	A. BUILDING _____ B. WING _____	03/14/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESLEYAN HEALTH CARE CENTER	729 WEST 35TH ST MARION, IN46953

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0000	This visit was for a Recertification and State Licensure Survey. This visit included the Investigation of Complaint IN00087124. Complaint IN00087124- Unsubstantiated due to lack of evidence. Survey dates: March 8, 9, 10, 11, and 14, 2011. Facility Number: 000557 Provider Number: 155455 AIM Number: 100291240 Survey team: Delinda Easterly, RN TC Ginger McNamee, RN Betty Retherford, RN	F0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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	Karen Lewis, RN Census bed type: SNF/NF: 130 Residential: 7 Total: 137 Census payor type: Medicare: 14 Medicaid: 88 Other: 35 Total: 137 Sample: 24 Residential Sample: 7 These deficiencies also reflect State Findings cited in accordance with 410 IAC 16.2. Quality review completed			

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	on March 16, 2011 by Bev Faulkner, RN			

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F0280 SS=A	Based on record review, observation, and interview, the facility failed to ensure the dietary department updated health care plans as indicated for 1 of 1 resident reviewed with a history of orders for fluid restrictions in a sample of 14 reviewed for accurate and updated health care plans. (Resident #117) Findings include: 1.) The clinical record for Resident #117 was reviewed on 3/10/11 at 8:50 a.m. Diagnoses for Resident #117 included, but were not	F0280	**F 280: CorrectiveActions Taken for those Residentsaffected by the alleged Deficientpractice:** Resident#117 care plan updated to reflectphysician order. **Identificationof and corrective actionstaken for other residents havingthe potential to be affected bythe alleged deficient practice:** Anyresident on fluid restriction has thepotential to be affected by the allegeddeficient practice. All care plans havebeen reviewed and correctedif indicated. **Measurestaken and systemic changes madeto ensure the alleged deficient practicedoes not recur:** All careplans for residents on fluid restrictionhave been reviewed and amended ifneeded. An in-service on physicianordered fluid restriction has beenscheduled on or before 3/31/2011. **Howthe corrective actions will be monitoredand the QA system implementedto ensure the alleged deficientpractice does not recur:** A qualityassurance audit will be completedby the Dietary Manager/ designeeon all residents with fluid restrictionorder and their care plans weekly for three months, and then quarterlyuntil 100% compliance. The results ofthe audit will be reviewed and anyconcerns addressed at the facility's quarterly QAmeetings.	03/31/2011

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	limited to, dementia and history of dehydration with hyponatremia (low sodium). A health care plan problem, revised on 3/7/11, indicated Resident #117 had a fluid restriction of 1500 cc (cubic centimeters). One of the interventions for this problem was "Restrict fluids per physician's order". The clinical record lacked any current physician's order for Resident #117 to have a fluid restriction. During observation on 3/10/11 at 12:10 p.m.,		**Dateof Completion**: March 31, 2011	

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	Resident #117 was in the dining room and was served approximate 720 cc of various liquids with her meal and a container of ice cream. During observation on 3/10/11 at 1:40 p.m., and 3/14/11 at 2:15 p.m., Resident #117 was up in a wheelchair in her room. A pitcher of water and a glass were within the resident's reach. During an interview with the Director of Nursing on 3/14/11 at 8:30 a.m., additional information was requested related to any order for fluid restrictions			

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	for Resident #117. During an interview on 3/14/11 at 9:00 a.m., the Director of Nursing indicated she had reviewed the "thinned file" for Resident #117. She indicated the resident once had an order for a 1500 cc fluid restriction, which had been discontinued on 10/6/09. Review of a physician's order, dated 10/6/09, obtained from the resident's "thinned file" indicated an order was received to discontinue the resident's fluid restrictions on 10/6/09. This indicated a			

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	time period of 17 months that this order had continued as current in the dietary health care plan. Review of the current facility policy, revised 6/2005, titled "Care Plans", provided by the Director of Nursing on 3/14/11 at 12:30 p.m., included, but was not limited to, the following: "Purpose: 1. To promote individualized resident care plans, with specific plans from nursing and other disciplines. 2. To provide continuity of			

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	care. 3. To provide a tool for evaluating quality of care and goal accomplishment.... Procedure: ...9. Each discipline will identify actual or potential problems/needs, care to be given; and goals to be accomplished.... 17. Quarterly evaluations will be conducted to determine the effectiveness or ineffectiveness of the approaches and goals 18. Problems approaches or goals which are met or			

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	discontinued will be crossed through with a yellow hi-lighter, labeled as D/C [discontinued] and dated...." 3.1-35(c)(1)			

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WESLEYAN HEALTH CARE CENTER	729 WEST 35TH ST MARION, IN46953

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F0282 SS=D	Based on record review and interview, the facility failed to ensure the nursing staff followed up on laboratory tests in a timely manner for 1 of 5 residents reviewed with physician's orders for a urinalysis with culture and sensitivity in a sample of 24. (Resident #116) Findings include: 1.) The clinical record for Resident #116 was reviewed on 3/8/11 at 11:05 a.m. Diagnoses for Resident #116 included, but were not limited to, severe Parkinson's disease and	F0282	**F 282:** **CorrectiveActions Taken for those residentsaffected by the alleged deficientpractice:** Unable tocorrect for resident #116 as theurinary tract infection is resolved. **Identificationof and corrective actionstaken for other residents havingthe potential to be affected by the alleged deficient practice:** Anyresident with a physician ordered urinalysiswith culture and sensitivity has thepotential to be affected by the allegeddeficient practice. The facility lab policyhas been reviewed, and the staff hasbeen in-serviced to include completinga lab requisition properly, on orbefore 3/31/2011. **Measures taken and systemic changes made to ensure the alleged deficient practice does not recur:** Thefacility lab policy has been	03/31/2011

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	altered mental status. A physician's order, dated 11/30/10, indicated Resident #116 was to have a urinalysis with culture and sensitivity due to possible symptoms of a urinary tract infection. A urinalysis report, dated 12/1/10, indicated the urine was abnormal due to the presence of bacteria and leukocytes. A hand written notation on the bottom of the laboratory (lab) report indicated the physician had been contacted and would wait for the culture and sensitivity (C&S) to be completed before any medications were ordered.		reviewed, and thestaff has been in-serviced on or before3/31/2011. **How the corrective actions will be monitored and the QA system implemented to ensure the alleged deficient practice does not recur:** A QualityAssurance audit will be completedby the Director of Nursing/ designeeon all physician orders for urinalysiswith culture and sensitivity for threemonths, and then quarterly until 100%compliance. The audits will bereviewed and any concerns addressedat the facility's quarterly QA meetings. **Dateof Completion**: March 31, 2011	

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	The clinical record lacked any C&S report related to the urinalysis completed on 12/1/10. During an interview with the Administrator and Director of Nursing (DoN) on 3/8/11 at 4:20 p.m., additional information was requested related to the lack of a C&S report. During an interview with the Assistant DoN on 3/9/11 at 3:15 p.m., she indicated the missing C&S report had been noted on 12/6/10 and the physician had been contacted. She indicated another order was received			

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	for a urinalysis with C&S. A physician's order, dated 12/06/10, indicated Resident #116 had a new order for a urinalysis and C&S if indicated. The clinical record indicated the urine sample was obtained on 12/6/10 at 6:00 p.m. The clinical record lacked any urinalysis report for a sample collected on 12/6/10. A urinalysis report, dated 12/9/10, indicated the lab had received a urine sample for testing on 12/9/10. The urinalysis report indicated			

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	the specimen was abnormal with bacteria and leukocytes present. The C&S report, dated 12/11/10, indicated the culture was positive for the organism, Proteus mirabilis. The report contained a list of antibiotics to which the organism was sensitive. A physician's order, dated 12/11/10, indicated the physician was contacted and an order was received for Cipro (an antibiotic) 250 milligrams twice daily for 10 days. This indicated a time period of 10 days from the date the first urine specimen was sent for testing and a final			

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	report was received and antibiotic therapy ordered. During an interview with the Administrator and DoN on 3/10/11 at 2:50 p.m., additional information was requested related to the urine specimen having been collected on 12/6/10 and the lab report indicating "specimen received" on 12/9/10. During an interview on 3/11/11 at 1:55 p.m., the DoN indicated she had consulted with the lab and was unable to determine how and/or why the specimen obtained on 12/6/10 was not tested until			

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	12/9/10. 2.) Review of the current facility policy, revised on December 2009, titled "Laboratory - Test Processing and Reporting", provided by the DoN on 3/14/11 at 12:30 p.m.; included, but was not limited to, the following: "Purpose: To assure physician-ordered diagnostic test are performed, and to assure that test results are promptly reported to the physician. Responsibility: Licensed Nursing and Director of			

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	Nursing Standards: ...6. A nurse is responsible for monitoring all test results received. 7. Test results are promptly reported to the physician or other practitioner who ordered them...." 3.1-35(g)(2)			

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F0323 SS=D	Based on observation, record review, and interview, the facility failed to ensure safety alarms ordered to help prevent unassisted ambulation and falls were in place and/or functional for 2 of 7 residents reviewed for placement of personal alarms in a sample of 24. (Resident # 118 and #35) Findings include: 1.) The clinical record for Resident #118 was reviewed on 3/8/11 at 5:00 p.m. Diagnoses for Resident	F0323	**F323:** **CorrectiveActions Taken for those residentaffected by the alleged deficientpractice:** Alarmingdevice was replaced for resident#118 immediately at the time of survey.Counseling given to CNA #7 who wasworking with resident #35. **Identificationof and corrective actionstaken for other residents havingthe potential to be affected by thealleged deficient practice:** Allresidents with alarms have the potentialto be affected by the alleged deficientpractice. All residents withalarms were checked for placementand proper functioning. Anin-service on alarms and facility policy hasbeen scheduled on or before 3/31/2011. **Measures taken and systemic changes made to ensure the alleged deficient practice does not recur:** Thefacility policy has been reviewed. Anin-service on checking alarms	03/31/2011

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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	#118 included, but were not limited to, history of open reduction and internal fixation of fractured right hip, Alzheimer's dementia, and osteoporosis. A nursing note, dated 2/21/11 at 9:40 a.m., indicated Resident #118 had fallen in her room when she attempted to ambulate without assistance. A fall risk assessment, dated 2/21/11, indicated Resident #118 scored in the "high risk for falls" category. A significant change Minimum Data Set		for placementand functioning has been completedby 3/31/2011. **Howthe corrective actions will be monitoredand the QA system implementedto ensure the alleged deficientpractice does not recur:** An auditwill be completed by the Directorof Nursing/Designee on three residentswith alarms per unit, five randomdays per week, to include all shifts,for three months, and then quarterlyuntil 100% compliance. The auditswill be reviewed and any concernsaddressed at the facility's quarterly QAmeetings. **Date of Completion**: March 31, 2011	

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WESLEYAN HEALTH CARE CENTER	729 WEST 35TH ST MARION, IN46953

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	assessment, dated 1/6/11, indicated Resident #118 required the assistance of the staff for transfers and toileting and had fallen on one occasion since the last assessment was completed on 12/15/10. A health care plan problem, dated 8/23/10 and last reviewed on 1/4/11, indicated Resident #118 was at risk for falls related to a history of falls, impaired balance, and use of psychotropic medications. One of the approaches for this problem was for the resident to have a bed alarm when in bed.			

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	155455	A. BUILDING _____ B. WING _____	03/14/2011

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	A recapitulation of physician's orders, dated 2/12/11, indicated Resident #118 was to have a "Bed alarm for safety - check placement and function every shift." During an observation conducted with LPN #3 on 3/11/11 at 1:10 p.m., Resident #118 was resting in bed and requested to be taken to the bathroom. CNA #4 assisted Resident #118 to a sitting position and then helped her up from the bed. The bed alarm did not sound when the resident was assisted out of bed. CNA #4 indicated the alarm may have become			

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	disconnected because the connection was loose. LPN #3 then checked the bed alarm. The cord leading from the pressure pad on the bed was not connected to the alarm box and was lying on the floor. When LPN #3 attempted to plug the plastic alarm clip into the alarm box, the connection was very loose. LPN #3 indicated the alarm needed to be replaced.			

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F0323 SS=D	2.) The clinical record for resident #35 was reviewed on 3/9/11 at 10:00 a.m. Resident #35's current diagnoses included, but were not limited to, fractured femur and chronic pulmonary heart disease. Resident #35 had a current physician's order, dated 2/9/11, for a bed alarm to be in place to the resident's bed. A healthcare plan, dated, 2/9/11 indicated the resident had a healthcare plan focus problem listed as, has had an actual fall with serious injury, left hip commuted intertrochanteric fracture at home, is at risk for further falls related to poor balance. An intervention for this problem was to provide a bed alarm to resident's bed. Review of "Fall Investigation Worksheets," for Resident #35, indicated the resident had fallen on 2/9 and 2/17. Review of a 3/2/11 "Fall Investigation Worksheet," indicated Resident #35 sustained a fall from the bed. The fall investigation indicated the bed alarm was not on the resident's bed at the time of the fall as ordered by the physician. During an interview with the Director of Nursing, on 3/14/11 at 10:00 a.m., she	F0323	**F323:** **CorrectiveActions Taken for those residentaffected by the alleged deficientpractice:** Alarmingdevice was replaced for resident#118 immediately at the time of survey.Counseling given to CNA #7 who wasworking with resident #35. **Identificationof and corrective actionstaken for other residents havingthe potential to be affected by thealleged deficient practice:** Allresidents with alarms have the potentialto be affected by the alleged deficientpractice. All residents withalarms were checked for placementand proper functioning. Anin-service on alarms and facility policy hasbeen scheduled on or before 3/31/2011. **Measures taken and systemic changes made to ensure the alleged deficient practice does not recur:** Thefacility policy has been reviewed. Anin-service on checking alarms	03/31/2011

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	indicated she had counseled CNA #7, who was working with Resident #35 on the evening of the fall. Review of the current undated facility policy, titled "Fall Management Protocol", provided by the Director of Nursing on 3/14/11 at 12:30 p.m., indicated the following, 1. Make sure fall risk assessments are completed on all residents on admission and quarterly. If the resident is identified at risk for falls what different intervention are put into place? 2. A fall risk care plan should be initiated for all residents on admission. Audit all resident clinical records for fall care plans and for appropriate interventions. ... 4. Put a new fall intervention in place immediately after the fall. Make sure the interventions are dated and placed on the fall care plan.... 9. When personal alarms are used there needs to be specific individual recommendations for each resident/. Be sure to monitor the functional ability of the personal alarms and monitors...."		for placementand functioning has been completedby 3/31/2011. **Howthe corrective actions will be monitoredand the QA system implementedto ensure the alleged deficientpractice does not recur:** An auditwill be completed by the Directorof Nursing/Designee on three residentswith alarms per unit, five randomdays per week, to include all shifts,for three months, and then quarterlyuntil 100% compliance. The auditswill be reviewed and any concernsaddressed at the facility's quarterly QAmeetings. **Date of Completion**: March 31, 2011	

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	3.1-45(a)(2)			

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F0371 SS=E	Based on observation, interview, and record review, the facility failed to ensure the dietary staff did not wear nail polish while preparing and serving food for 2 of 4 dietary staff observed for 2 of 3 observations, and failed to ensure pans and equipment were stored in a manner to prevent contamination. This had the potential to affect 129 residents served meals from the facility kitchen. [Dietary Staff #1 and #2] Findings include: The following observations were made during the initial kitchen observation 3/8/11 from 9:10 a.m. to 9:25 a.m.: 1. A purse was sitting on a shelf with the clean steam table pans. 2. Three clean cutting boards were stored on the back ledge of the three basin sink behind the leaking faucet and were sprayed with water when the faucet was turned on. A second observation of the kitchen was made on 3/8/11 from 11:15 a.m. to 11:40 a.m., with the following observations made: 1. Dietary Employee #1 was plating food to be placed on the food carts. The	F0371	**F371:** **CorrectiveActions Taken for those residentaffected by the alleged deficientpractice:** Immediatein-service for all dietary staffpertaining to storage of personal items,nail polish, artificial nails, properstorage of cutting boards, cereal bowls, andreview of sanitation and crosscontamination policy and procedure.All nail polish and artificial nails wereremoved at the time of survey. Bowls andcutting boards where correctlystored after identification of allegeddeficient practice. **Identificationof and corrective actionstaken for other residents havingthe potential to be affected by thealleged deficient practice:** Allresidents receiving a meal tray have thepotential to be affected by the allegeddeficient practice. Immediate in-serviceof all dietary staff on facilitypolicy and procedure related tosanitation and cross contamination. **Measures taken and systemic**	03/31/2011

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	employee's fingernails were polished and the employee was not wearing gloves on her hands. 2. A full rack of cereal bowls being used during the meal service had wet bottoms. Dietary Employee #1 indicated the bowls come out of the dish washer with water standing on the bottom and can't dry. 3. Dietary Employee #2 opened the lid on the trash container two times with her bare hands and continued to open drawers and remove utensils. She pulled up the back of her pants twice with her bare hands and continued to wrap utensils in aluminum foil for transportation to the Fireside dining room. No handwashing was observed. The current 7/08, "Handwashing" policy and procedure for nutritional services was provided on 3/14/11 at 10:10 a.m., by the Administrator. The policy indicated hands should be washed after handling soiled articles. The current 7/08, "Personal Hygiene and Jewelry" policy and procedure for nutritional services was provided by the Administrator on 3/14/11 at 10:10 a.m. The policy indicated food service employees may not wear fingernail polish		**changes** **made to ensure the alleged deficient** **practice does not recur:** Thefacility policy has been reviewed, and thedietary staff have been in-servicedon sanitation and cross contamination.Appropriate signage has beenplaced to alert staff to proper procedures. **Howthe corrective actions will be** **monitoredand the QA system implementedto ensure the alleged** **deficientpractice does not recur:** An auditwill be completed by the DietaryManager/Designee on storage of bowls,cutting boards, and employee items toensure items are stored properlyfive random days per week, to includeeach meal service and weekends, for threemonths, then quarterly until 100%compliance met. An audit will also becompleted by the Dietary Manager/Designee on hand washing to preventcross contamination by visualizingstaff while working, five randomdays per week, to include each	

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	or artificial fingernails unless they are wearing gloves. During an interview with the Registered Dietician on 3/14/11 at 12:45 p.m., she indicated dietary staff are not to wear nail polish unless they are wearing gloves and hands should be washed after touching the lid to the trash container. She indicated the cutting boards are to be stored on the wire racks and not on the back ledge of the three basin sink. 3.1-21(i)(1) 3.1-21(i)(3)		mealservice and weekends, for three months,then quarterly until 100% compliancemet. All audits will be reviewedand any concerns addressed infacility's quarterly QA meetings. **Date of Completion**: March 31, 2011	